Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA SPRING BRANCH
C/O T DANIEL HOLLAWAY
808 TRAVIS ST STE 1700
HOUSTON TX 77002-5703

Respondent Name
INSURANCE COMPANY OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-98-6331-01

MFDR Date Received
August 21, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the issue of which employer was liable for the claimant's coverage under the Act has now been resolved, it is our understanding that the Medical Review Division may now proceed to review these medical claims and enter its decision."

Amount in Dispute: $142,919.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills were properly paid pursuant to the per diem rates and other provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline. . . . While the Guideline was invalidated as a TWCC rule based upon procedural error in its adoption, the per diem rates and methodology of the Guideline remain a valid measure of fair and reasonable reimbursement. . . . The requester has failed to meet its burden to show that the reimbursement received was insufficient under the requirements of the Texas Labor Code. Therefore, Carrier requests a determination that the requester is not entitled to further reimbursement for the dates of service."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 1996 to January 25, 1997	Outpatient Hospital Services	$142,919.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
   - E – Entitlement (non-compensable)
   - M – Reduced to Fair and Reasonable
   - N – Not Documented
   - R – Charge Unrelated to Compensable Injury
   - T – Not According to Treatment Guidelines
   - U – Unnecessary Medical Treatment or Services.

Findings

1. The insurance carrier denied disputed services with payment exception codes E – "Entitlement (non-compensable)" and R – "Charge Unrelated to Compensable Injury." The Texas Workers' Compensation Commission Appeals Panel issued a decision on August 26, 1997, which held that "the claimant sustained a compensable head injury while employed by, or acting as the borrowed servant of, H Company, and that the carrier in its capacity as insurer for H company is liable for benefits." Subsequent to the appeals panel decision, the insurance carrier issued payment for the services in dispute. The Division therefore concludes that the issues related to entitlement and compensability are no longer in dispute.
2. The insurance carrier denied disputed services with payment exception codes T – "Not According to Treatment Guidelines" and U – "Unnecessary Medical Treatment or Services." However, subsequent to the above appeals panel decision, the insurance carrier issued payments for the disputed services. Per former 28 Texas Administrative Code §133.300(f), effective February 20, 1992, 17 Texas Register 1105, "If the carrier disputes the health care provider's charge, the carrier shall notify the provider of the reduction as described in §133.304 of this title (relating to Notice of Medical Payment Dispute)." Per former 28 Texas Administrative Code §134.304(b), effective February 20, 1992, 17 Texas Register 1105, "Except when disputed charges are limited to reductions according to an explicitly stated fee guideline or negotiated contract amounts, a copy of the notice of medical payment dispute shall be sent to the health care provider and a copy shall be kept in the injured employee's file at the carrier's office." The insurance carrier did not submit copies of any explanations of benefits or TWCC form 62 Notices of Medical Payment Dispute regarding payment for the disputed services. No documentation was found to support that the insurance carrier maintained these denial reasons upon payment. The Division therefore concludes that these denial reasons are no longer at issue and that only medical fee issues remain to be decided. The disputed services will therefore be reviewed according to applicable Division rules and fee guidelines.
3. This dispute relates to both inpatient and outpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied).
4. Neither the inpatient nor outpatient hospital services in dispute were identified in an established fee guideline during the disputed dates of service; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission."
5. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
6. Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.

- The requestor's position statement dated August 20, 1997asserts that "it is the position of Columbia Spring Branch Medical Center that all charges relating to the admissions . . . are due and payable as provided for under Texas law."
- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	December 5, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
	Mary Landrum	
Signature	Director, Health Care Business Management	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.